Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
A043 GOVERNING BODY CFR(s) 482.12	The Governing Board failed to ensure that the facility perform preliminary examinations for medical stability and criteria for admission on new arrivals; that arrivals under emergency detention were provided with notice of their rights under emergency detention warrants; that new arrivals were appropriately assessed, monitored for safety and received appropriate diets and basic health needs while awaiting assessment and admission.	The Chief Executive Officer (CEO) held an emergency Medical Executive Committee meeting and ad hoc Governing Board meeting to apprise members of issues identified and gain consensus on corrective action plans. The Governing board voted to approve all the revisions and development of policies and protocols as described herein. A new policy on “diversion process” was developed to minimize the number of patients waiting for a bed in Intake. Additionally, the CEO has obtained the support of the Local Mental Health Community Center (North Texas Behavioral Health Authority - NTBHA) to have first access to available beds for NTBHA crisis residential beds if patient is appropriate for that level of care.	CEO	9/28/18
A043 GOVERNING BODY CFR(s) 482.12 Section A	Failed to perform a preliminary assessment of medical stability to determine if individuals met the criteria for admission for emergency detention**.**	Policy #100.06 titled “Medical Assessment and Patient Monitoring at Admission” was developed to ensure all Individuals presenting for assessment are provided with an appropriate medical screening examination to determine whether or not an emergency medical condition exists. The examination will be conducted by an individual who is determined qualified by hospital bylaws (Physician. Physician Assistant, Nurse Practioner, or Registered Nurse). If an emergency medical condition is determined to exist, hospital staff will provide any necessary stabilizing treatment,	CEO	Completed on 9/21/18

Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		or transfer as appropriate.		
		Education to be provided to all Intake Registered Nurses on Policy #100.06. All full-time staff will be trained by 10/5 PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Director of Education	10/10/18
		Sustainability: Audits of documentation on 100% of individuals presenting for potential admissions will be reviewed daily by the Intake Director or designee for presence of preliminary assessment. Upon achieving 100% compliance for 30 days, random audits of the documentation on 50 individuals presenting for admission will be conducted for 90-days. Audit results will be reported monthly at the Performance Improvement Committee meeting and the Medical Executive Committee meeting and Quarterly to the Governing Board.	Intake Director	10/10/18 and Ongoing
	Failed to ensure that patients arriving under emergency detention warrants were provided with a copy of their rights**.**	All Intake staff will be re-trained on the requirement that all patients are provided a copy of "Patient Bill of Rights." All full-time Intake staff will be re-trained by 10/5 PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Intake Director	10/1/18
		Sustainability: Random audits of 50% of admissions will be conducted weekly by the Intake Director or designee for compliance with documentation of provision of patient	Intake Director	10/10/18 and Ongoing

Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		rights to patients. Upon achieving 100% compliance on weekly audits for 4 consecutive weeks, random audits will be conducted monthly on 50 charts of new admissions on a monthly basis. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.		
	Failed to ensure the appropriate assessment and safe monitoring of individuals who were being held under emergency detention while awaiting assessment and admission.	Policy #100.06 titled "Medical Assessment and Patient Monitoring at Admission" was developed to ensure that all Individuals presenting for assessment are medically screened for early detection of symptoms or illnesses that may constitute an urgent or emergent medical situation warranting transfer or alternative disposition. Included in the policy are the elements below- • Medical Screening, upon arrival • Nursing assessment every shift and vital signs every four hours until disposition is reached • Physician preliminary examination as soon as possible but no later than 24-hours after arrival • Patient Observation rounds at least every 15 minutes	CEO	Completed on 9/21/18
		The Intake Director and Director of Education shall train all Intake staff on the policy and corresponding forms. All full-time Intake staff will be re-trained by 10/5. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift.	Intake Director Director of Education	10/10/18 and Ongoing

Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		Documentation of training will be evident in staff's education files.		
		Sustainability: Random audits of 50% of admissions will be conducted weekly by the Intake Director or designee for compliance with documentation screening, assessments, preliminary examination and observations. Upon achieving 100% compliance on weekly audits for 4 consecutive weeks, random audits will be conducted monthly on 50 charts of new admissions for 90 days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.	Intake Director	10/10/18 and Ongoing
	Failed to ensure individuals received appropriate diet and basic health needs while awaiting assessment and admission.	New Policy 100.33 titled "Caring for Patient Needs in Intake" developed to ensure the basic health needs, to include dietary, personal hygiene, activities and comfort, of patients who are waiting in Intake are met.	CEO	Completed on 9/21/18
		The Intake Director and Director of Education shall train all Intake staff on the policy and corresponding forms. All full-time Intake staff will be re-trained by 10/5. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Intake Director Director of Education	10/10/18
		Sustainability: Random audits will be conducted monthly on 50 charts of new admissions, with a target of 95% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive	Intake Director	10/10/18 and Ongoing

Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		Committee and Quarterly to the Governing Board.		
A043 GOVERNING BODY CFR(s) 482.12 Section B	Failed to follow its own policy to ensure that patients were being monitored per physician orders for safety.	Policy 200.29 titled “Rounds for Patient Observation” was revised to include additional observational levels.	CEO Medical Director	Completed on 9/21/18
		The Director of Education will educate all Registered Nurses, Licensed Vocational Nurses, and Mental Health Technicians on revised policy 200.29 “Rounds for Patient Observation.” All full-time nursing staff will be re-trained by 10/10. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff’s education files.	Director of Education	10/10/18
		Sustainability: Random Daily Leadership Rounds will be conducted to ensure patient observations are being carried out as ordered by physicians. Findings of Leadership Rounds will be reported daily to nursing administration and weekly to CEO during management meeting.	CEO	10/10/18 and Ongoing
	Failed to ensure that patient’s guardians and CPS were notified of patient sexual abuse.	The Director of Social Services re-educated all social services staff on Policy 212.01 titled “Abuse Reporting” Which includes proper reporting procedure, notification of Legally Authorized Representative (LAR) and documentation of calls.	Director of Social Services	Completed on 9/28/18
		Notification emails will be sent to Director of Social Services by social services staff when a CPS report is completed. The Social Services Director shall maintain a log of CPS calls.	Director of Social Services	10/10/18 and Ongoing

Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		Sustainability: The Social Service Director will audit 50% of records of patients listed on the CPS Notification Log to ensure compliance with notification of LAR and CPS, with a target of 95% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.	Director of Social Services	10/10/18 and Ongoing
	Failed to address in the treatment plans patient's behavior that could result in risk of harm to self or others	New Master Treatment Plan was developed to allow more individualization, to include behaviors that could result in risk of harm to self or others.	CNO	9/21/18
		The Director of Education and Director of Social Services will re-educate all RNs and Social Service Staff on new Master Treatment Plan and proper treatment planning, including adding additional problems to the treatment plan when necessary and on the new forms. All full-time nursing and social service staff will be re-trained by 10/5. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Director of Education Director of Social Services	10/10/18
		Sustainability: Random audits will be conducted monthly on 50 charts, with a target of 95% compliance for 90-days. Audit results will continue to be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.	CNO Director of Social Services	10/10/18 and Ongoing

Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
A043 GOVERNING BODY CFR(s) 482.12 Section C	Failed to provide needed clothes to promote patient dignity and avoid mental anguish.	A *"Caring Closet"* program was developed for the purpose of providing clothing, footwear, and other essential personal items for patients who may not have the resources to ensure dignity is preserved.	Director of Social Services	10/1/18
		Sustainability: Daily Leadership Rounds will be conducted to ensure patients are provided adequate clothing. Findings of Leadership Rounds will be reported daily to nursing administration and weekly to CEO during management meeting.	CEO	10/10/18 and Ongoing
A043 GOVERNING BODY CFR(s) 482.12 Section D	Failed to provide patients a place to sit or lie down while being secluded.	Eight new chairs will be purchased to be placed in the seclusion rooms. These chairs will be securely mounted to the floor in a manner that ensures patient safety. New chairs will be ordered by 10/5/2018 and delivery is expected on 11/16/2018. Until new seclusion room chairs arrive, beds will be mounted in seclusion rooms.	CEO	10/5/18
A043 GOVERNING BODY CFR(s) 482.12 Section E	Failed to ensure all Medicare and Medicare Advantage patients were provided with appropriate notice of rights within 2 days of discharge.	The Director of Utilization Review implemented a process of ensuring that all Medicare and Medicare Advantage patients are provided with a follow-up copy of their notice of rights within 2 days of discharge.	Director of Utilization Review	Completed 9/28/18
		The Director of Utilization Review educated all UR staff that it is mandatory that all Medicare and Medicare Advantage patients receive a follow-up copy of their notice of rights within 2 days of discharge, including the process for delivering and explaining these rights to patients as well as documentation in the Medical Record.	Director of Utilization Review	Completed 9/28/18
		Sustainability: Random audits will be	Director of	10/10/18 and

Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		conducted monthly on 50 charts, with a target of 95% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board	Utilization Review	Ongoing
A043 GOVERNING BODY CFR(s) 482.12 Section F	Failed to provide the necessary information for informed consent and/or provide it in a manner the patient was able to understand.	The existing medication consent form (MHRS 9-7.1) was modified to include all required elements needed to properly document patient's informed consent per CMS standards.	Director of RM/PI	Completed 9/21/18
		The Director of Education will conduct in-service training for all nursing personnel on the proper procedure for obtaining and documenting medication consents, including how to obtain interpretation services when needed. All full-time nurses will be re-trained by 10/10. PRN nurses not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Director of Education	10/10/18
		Patient education material will be made available on all units for all psychotropic medications in DBHH formulary. Education material will be made available in English and Spanish and/or interpretation services will be provided.	Director of Pharmacy	10/8/18
		Sustainability: Random audits will be conducted monthly on 50 charts with a target of 100% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and	CNO	10/10/18 and Ongoing

Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		Medical Executive Committee and Quarterly to the Governing Board.		
A043 GOVERNING BODY CFR(s) 482.12 Section G	Failed to provide the patient privacy when clinical care issues were discussed between the patient and the physician.	Physicians will be re-educated on appropriate locations to conduct patient assessments that will ensure both patient privacy and patient/staff safety.	CEO Medical Director	10/1/18
		The Director of Education will conduct in-service training for all nursing personnel on the proper procedure for conducting patient assessments and interviews. All full-time nurses will be re-trained by 10/5. PRN nurses not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Director of Education	10/10/18
		Sustainability: Daily Leadership Rounds will be conducted to ensure patients afforded privacy when discussing private matter. Findings of Leadership Rounds will be reported daily to nursing administration and weekly to CEO during management meeting	CEO	10/10/18 and ongoing
A043 GOVERNING BODY CFR(s) 482.12 Section H	Failed to ensure the environment was sanitary to prevent infectious sources or the spread of infection.	In addition to departmental environmental rounds (see Tag 747), the Infection Control Rounds conducted by the Director of Infection Control have been expanded and include surveillance of Intake department, patient living areas, medication rooms, unit refrigerators, treatment rooms, seclusion rooms, furniture, courtyards, dining room and kitchen.	Director of Infection Control	10/5/18
		Sustainability: Director of Infection Control will conduct monthly facility rounds and report findings to EOC Committee and	Director of Infection Control	10/10/18 and Ongoing

Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		Medical Executive Committee monthly, and Governing Board quarterly.		
A115 PATIENT RIGHTS CFR(s) 482.13 Section A	Failed to perform a preliminary assessment of medical stability to determine if individuals met the criteria for admission for emergency detention**.**	Policy #100.06 titled “Medical Assessment and Patient Monitoring at Admission” was developed to ensure all Individuals presenting for assessment are provided with an appropriate medical screening examination to determine whether or not an emergency medical condition exists. The examination will be conducted by an individual who is determined qualified by hospital bylaws (Physician. Physician Assistant, Nurse Practioner, or Registered Nurse). If an emergency medical condition is determined to exist, hospital staff will provide any necessary stabilizing treatment, or transfer as appropriate.	CEO	Completed on 9/21/18
		Education to be provided to all Intake Registered Nurses on Policy #100.06. All full-time staff will be trained by 10/5 PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff’s education files.	Director of Education	10/10/18
		Sustainability: Audits of documentation on 100% of individuals presenting for potential admissions will be reviewed daily by the Intake Director or designee for presence of preliminary assessment. Upon achieving 100% compliance for 30 days, random audits of the documentation on 50 individuals presenting for admission will be conducted for 90-days. Audit results will be reported monthly at the Performance	Intake Director	10/10/18 and Ongoing

Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		Improvement Committee meeting and the Medical Executive Committee meeting and Quarterly to the Governing Board.		
	Failed to ensure that patients arriving under emergency detention warrants were provided with a copy of their rights**.**	All Intake staff will be re-trained on the requirement that all patients are provided a copy of "Patient Bill of Rights." All full-time Intake staff will be re-trained by 10/5 PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Intake Director	10/1/18
		Sustainability: Random audits of 50% of admissions will be conducted weekly by the Intake Director or designee for compliance with documentation of provision of patient rights to patients. Upon achieving 100% compliance on weekly audits for 4 consecutive weeks, random audits will be conducted monthly on 50 charts of new admissions with a target of 95% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.	Intake Director	10/10/18 and Ongoing
	Failed to ensure the appropriate assessment and safe monitoring of individuals who were being held under emergency detention while awaiting assessment and admission.	Policy #100.06 titled "Medical Assessment and Patient Monitoring at Admission" was developed to ensure that all Individuals presenting for assessment are medically screened for early detection of symptoms or illnesses that may constitute an urgent or emergent medical situation warranting transfer or alternative disposition. Included	CEO	Completed on 9/21/18

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TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		in the policy are the elements below- • Medical Screening, upon arrival • Nursing assessment every shift and vital signs every four hours until disposition is reached • Physician preliminary examination as soon as possible but no later than 24-hours after arrival • Patient Observation rounds at least every 15 minutes		
		The Intake Director and Director of Education shall train all Intake staff on the policy and corresponding forms. All full-time Intake staff will be re-trained by 10/5. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Intake Director Director of Education	10/10/18 and Ongoing
		Sustainability: Random audits of 50% of admissions will be conducted weekly by the Intake Director or designee for compliance with documentation screening, assessments, preliminary examination and observations. Upon achieving 100% compliance on weekly audits for 4 consecutive weeks, random audits will be conducted monthly on 50 charts of new admissions for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.	Intake Director	10/10/18 and Ongoing
	Failed to ensure individuals received appropriate diet and basic health needs	New Policy 100.33 titled "Caring for Patient Needs in Intake" developed to ensure the basic health needs, to include dietary,	CEO	Completed on 9/21/18

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TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
	while awaiting assessment and admission.	personal hygiene, activities and comfort, of patients who are waiting in Intake are met.		
		The Intake Director and Director of Education shall train all Intake staff on the policy and corresponding forms. All full-time Intake staff will be re-trained by 10/5. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Intake Director Director of Education	10/10/18
		Sustainability: Random audits will be conducted monthly on 50 charts of new admissions with a target of 95% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.	Intake Director	10/10/18 and Ongoing
A115 PATIENT RIGHTS CFR(s) 482.13 Section B	Failed to follow its own policy to ensure that patients were being monitored per physician orders for safety.	Policy 200.29 titled "Rounds for Patient Observation" was revised to include additional observational levels.	CEO Medical Director	Completed 9/21/18
		The Director of Education will educate all Registered Nurses, Licensed Vocational Nurses, and Mental Health Technicians on revised policy 200.29 "Rounds for Patient Observation." All full-time nursing staff will be re-trained by 10/10. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Director of Education	10/10/18
		Sustainability: Random Daily Leadership	CEO	10/10/18

Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		Rounds will be conducted to ensure patient observations are being carried out as ordered by physicians. Findings of Leadership Rounds will be reported daily to nursing administration and weekly to CEO during management meeting.		and Ongoing
	Failed to ensure that patient's guardians and CPS were notified of patient sexual abuse.	The Director of Social Services re-educated all social services staff on Policy 212.01 titled "Abuse Reporting" Which includes proper reporting procedure, notification of Legally Authorized Representative (LAR) and documentation of calls.	Director of Social Services	Completed 9/28/18
		Notification emails will be sent to Director of Social Services by social services staff when a CPS report is completed. The Social Services Director shall maintain a log of CPS calls.	Director of Social Services	10/10/18 and Ongoing
		<u>Sustainability:</u> The Social Service Director will audit 50% of records of patients listed on the CPS Notification Log to ensure compliance with notification of LAR and CPS with a target of 95% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.	Director of Social Services	10/10/18 and Ongoing
	Failed to address in the treatment plans patient's behavior that could result in risk of harm to self or others	New Master Treatment Plan was developed to allow more individualization, to include behaviors that could result in risk of harm to self or others.	CNO	Completed 9/21/18
		The Director of Education and Director of Social Services will re-educate all RNs and Social Service Staff on new Master Treatment Plan and proper treatment planning,	Director of Education Director of	10/10/18

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TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		including adding additional problems to the treatment plan when necessary and on the new forms. All full-time nursing and social service staff will be re-trained by 10/5. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Social Services	
		<u>Sustainability:</u> Random audits will be conducted monthly on 50 charts with a target of 95% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.	CNO Director of Social Services	10/10/18 and Ongoing
A115 PATIENT RIGHTS CFR(s) 482.13 Section C	Failed to provide needed clothes to promote patient dignity and avoid mental anguish.	A *"Caring Closet"* program was developed for the purpose of providing clothing, footwear, and other essential personal items for patients who may not have the resources to ensure dignity is preserved.	Director of Social Services	10/1/2018
		<u>Sustainability:</u> Daily Leadership Rounds will be conducted to ensure patients have adequate clothing. Findings of Leadership Rounds will be reported daily to nursing administration and weekly to CEO during management meeting	CEO	10/10/18 and Ongoing
A115 PATIENT RIGHTS CFR(s) 482.13	Failed to provide patients a place to sit or lie down while being secluded.	Eight new chairs will be purchased to be placed in the seclusion rooms. These chairs will be securely mounted to the floor in a manner that ensures patient safety. New chairs will be ordered by 10/5/2018 and	CEO	10/5/2018

Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
Section D		delivery is expected on 11/16/2018. Until new seclusion room chairs arrive, beds will be mounted in seclusion rooms.		
A115 PATIENT RIGHTS CFR(s) 482.13 Section E	Failed to ensure all Medicare and Medicare Advantage patients were provided with appropriate notice of rights within 2 days of discharge.	The Director of Utilization Review implemented a process of ensuring that all Medicare and Medicare Advantage patients are provided with a follow-up copy of their notice of rights within 2 days of discharge.	Director of Utilization Review	Completed 9/28/18
		The Director of Utilization Review educated all UR staff that it is mandatory that all Medicare and Medicare Advantage patients receive a follow-up copy of their notice of rights within 2 days of discharge, including the process for delivering and explaining these rights to patients as well as documentation in the Medical Record.	Director of Utilization Review	Completed 9/28/18
		Sustainability: Random audits will be conducted monthly on 50 charts with a target of 95% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board	Director of Utilization Review	10/10/18 and Ongoing
A115 PATIENT RIGHTS CFR(s) 482.13 Section F	Failed to provide the necessary information for informed consent and/or provide it in a manner the patient was able to understand.	The existing medication consent form (MHRS 9-7.1) was modified to include all required elements needed to properly document patient's informed consent per CMS standards.	Director of RM/PI	Completed 9/21/18
		The Director of Education will conduct in-service training for all nursing personnel on the proper procedure for obtaining and documenting medication consents, including how to obtain interpretation services when needed. All full-time nurses will be re-	Director of Education	10/10/18

Dallas Behavioral Healthcare Hospital - CMS Survey Corrective Action Plan 8-31-2018				
TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		trained by 10/10. PRN nurses not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.		
		Patient education material will be made available on all units for all psychotropic medications in DBHH formulary. Education material will be made available in English and Spanish and/or interpretation services will be provided.	Director of Pharmacy	10/8/2018
		Sustainability: Random audits will be conducted monthly on 50 charts with a target of 100% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board	CNO	10/10/18 and Ongoing
A115 PATIENT RIGHTS CFR(s) 482.13 Section G	Failed to provide the patient privacy when clinical care issues were discussed between the patient and the physician.	Physicians will be re-educated on appropriate locations to conduct patient assessments that will ensure both patient privacy and patient/staff safety.	CEO Medical Director	10/1/2018
		The Director of Education will conduct in-service training for all nursing personnel on the proper procedure for conducting patient assessments and interviews. All full-time nurses will be re-trained by 10/5. PRN nurses not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Director of Education	10/10/2018

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TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
		<u>Sustainability:</u> Daily Leadership Rounds will be conducted to ensure patients afforded privacy when discussing private matter. Findings of Leadership Rounds will be reported daily to nursing administration and weekly to CEO during management meeting	CEO	10/10/18 and Ongoing
A117 PATIENT RIGHTS: NOTICE OF RIGHTS CFR(s) 482.13(a)(1)	Failed to ensure all Medicare and Medicare Advantage patients were provided with appropriate notice of rights within 2 days of discharge.	The Director of Utilization Review implemented a process of ensuring that all Medicare and Medicare Advantage patients are provided with a follow-up copy of their notice of rights within 2 days of discharge.	Director of Utilization Review	Completed 9/28/18
		The Director of Utilization Review educated all UR staff that it is mandatory that all Medicare and Medicare Advantage patients receive a follow-up copy of their notice of rights within 2 days of discharge, including the process for delivering and explaining these rights to patients as well as documentation in the Medical Record.	Director of Utilization Review	Completed 9/28/18
		<u>Sustainability:</u> Random audits will be conducted monthly on 50 charts with a target of 95% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board	Director of Utilization Review	10/10/18 and Ongoing
A131 PATIENT RIGHTS: INFORMED	Failed to provide the necessary information for informed consent and/or provide it in a manner the	The existing medication consent form (MHRS 9-7.1) was modified to include all required elements needed to properly document patient's informed consent per CMS	Director of RM/PI	Completed 9/21/18

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TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
CONSENT CFR(s) 482.13(b)(2)	patient was able to understand.	standards.		
		The Director of Education will conduct in-service training for all nursing personnel on the proper procedure for obtaining and documenting medication consents, including patient and staff signatures, obtaining consent, withdrawing consent and how to obtain interpretation services when needed. All full-time nurses will be re-trained by 10/10. PRN nurses not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Director of Education	10/10/18
		Patient education material will be made available on all units for all psychotropic medications in DBHH formulary. Education material will be made available in English and Spanish and/or interpretation services will be provided.	Director of Pharmacy	10/8/2018
		<u>Sustainability:</u> Random audits will be conducted monthly on 50 charts with a target of 100% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.	CNO	10/10/18 and Ongoing
A143 PATIENT RIGHTS: PERSONAL PRIVACY	Failed to provide the patient privacy when clinical care issues were discussed between the patient and the physician.	Physicians will be re-educated on appropriate locations to conduct patient assessments that will ensure both patient privacy and patient/staff safety.	CEO Medical Director	10/1/2018

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TAG #	**ITEM**	**ACTION**	**RESPONSIBLE STAFF**	**COMPLETION DATE**
CFR(s) 482.13(c)(1)		The Director of Education will conduct in-service training for all nursing personnel on the proper procedure for conducting patient assessments and interviews. All full-time nurses will be re-trained by 10/5. PRN nurses not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Director of Education	10/10/2018
		Sustainability: Daily Leadership Rounds will be conducted to ensure patients afforded privacy when discussing private matter. Findings of Leadership Rounds will be reported daily to nursing administration and weekly to CEO during management meeting.	CEO	10/10/18 and Ongoing
A144 PATIENT RIGHTS: CARE IN A SAFE SETTING CFR(s) 482.13(c)(2) Section A	Failed to perform a preliminary assessment of medical stability to determine if individuals met the criteria for admission for emergency detention**.**	Policy #100.06 titled "Medical Assessment and Patient Monitoring at Admission" was developed to ensure all Individuals presenting for assessment are provided with an appropriate medical screening examination to determine whether or not an emergency medical condition exists. The examination will be conducted by an individual who is determined qualified by hospital bylaws (Physician. Physician Assistant, Nurse Practioner, or Registered Nurse). If an emergency medical condition is determined to exist, hospital staff will provide any necessary stabilizing treatment, or transfer as appropriate.	CEO	Completed on 9/21/18
		Education to be provided to all Intake Registered Nurses on Policy #100.06. All full-	Director of Education	10/10/18

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		time staff will be trained by 10/5 PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.		
		Sustainability: Audits of documentation on 100% of individuals presenting for potential admissions will be reviewed daily by the Intake Director or designee for presence of preliminary assessment. Upon achieving 100% compliance for 30 days, random audits of the documentation on 50 individuals presenting for admission for 90-days. Audit results will be reported monthly at the Performance Improvement Committee meeting and the Medical Executive Committee meeting and Quarterly to the Governing Board.	Intake Director	10/10/18 and Ongoing
	Failed to ensure that patients arriving under emergency detention warrants were provided with a copy of their rights.	All Intake staff will be re-trained on the requirement that all patients are provided a copy of "Patient Bill of Rights." All full-time Intake staff will be re-trained by 10/5 PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Intake Director	10/1/18
		Sustainability: Random audits of 50% of admissions will be conducted weekly by the Intake Director or designee for compliance with documentation of provision of patient rights to patients. Upon achieving 100% compliance on weekly audits for 4 consecutive weeks, random audits will be conducted monthly on 50 charts of new	Intake Director	10/10/18 and Ongoing

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		admissions for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.		
	Failed to ensure the appropriate assessment and safe monitoring of individuals who were being held under emergency detention while awaiting assessment and admission.	Policy #100.06 titled "Medical Assessment and Patient Monitoring at Admission" was developed to ensure that all Individuals presenting for assessment are medically screened for early detection of symptoms or illnesses that may constitute an urgent or emergent medical situation warranting transfer or alternative disposition. Included in the policy are the elements below- • Medical Screening, upon arrival • Nursing assessment every shift and vital signs every four hours until disposition is reached • Physician preliminary examination as soon as possible but no later than 24-hours after arrival Patient Observation rounds at least every 15 minutes	CEO	Completed on 9/21/18
		The Intake Director and Director of Education shall train all Intake staff on the policy and corresponding forms. All full-time Intake staff will be re-trained by 10/5. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Intake Director Director of Education	10/10/18
		Sustainability: Random audits of 50% of admissions will be conducted weekly by the Intake Director or designee for compliance	Intake Director	10/10/18 and Ongoing

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		with documentation screening, assessments, preliminary examination and observations. Upon achieving 100% compliance on weekly audits for 4 consecutive weeks, random audits will be conducted monthly on 50 charts of new admissions with a target of 100% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.		
	Failed to ensure individuals received appropriate diet and basic health needs while awaiting assessment and admission.	New Policy 100.33 titled “Caring for Patient Needs in Intake” developed to ensure the basic health needs, to include dietary, personal hygiene, activities and comfort, of patients who are waiting in Intake are met.	Intake Director	Completed on 9/21/18
		The Intake Director and Director of Education shall train all Intake staff on the policy and corresponding forms. All full-time Intake staff will be re-trained by 10/5. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff’s education files.	Intake Director Director of Education	10/10/18
		<u>Sustainability:</u> Random audits will be conducted monthly on 50 charts of new admissions. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.	Intake Director	10/10/18 and Ongoing

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A144 PATIENT RIGHTS: CARE IN A SAFE SETTING CFR(s) 482.13(c)(2) Section B	Failed to follow its own policy to ensure that patients were being monitored per physician orders for safety.	Policy 200.29 titled “Rounds for Patient Observation” was revised to include additional observational levels.	Medical Director	Completed 9/21/18
		The Director of Education will educate all Registered Nurses, Licensed Vocational Nurses, and Mental Health Technicians on revised policy 200.29 “Rounds for Patient Observation.” All full-time nursing staff will be re-trained by 10/10. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff’s education files.	Director of Education	10/10/18
		Sustainability: Random Daily Leadership Rounds will be conducted to ensure patient observations are being carried out as ordered by physicians. Findings of Leadership Rounds will be reported daily to nursing administration and weekly to CEO during management meeting.	CEO	10/10/18 and Ongoing
	Failed to ensure that patient’s guardians and CPS were notified of patient sexual abuse.	The Director of Social Services re-educated all social services staff on Policy 212.01 titled “Abuse Reporting” Which includes proper reporting procedure, notification of Legally Authorized Representative (LAR) and documentation of calls.	Director of Social Services	Completed 9/28/18
		Notification emails will be sent to Director of Social Services by social services staff when a CPS report is completed. The Social	Director of Social Services	10/10/18 and Ongoing

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		Services Director shall maintain a log of CPS calls.		
		<u>Sustainability:</u> The Social Service Director will audit 50% of records of patients listed on the CPS Notification Log to ensure compliance with notification of LAR and CPS with a target of 95% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.	Director of Social Services	10/10/18 and Ongoing
	Failed to address in the treatment plans patient's behavior that could result in risk of harm to self or others	New Master Treatment Plan was developed to allow more individualization, to include behaviors that could result in risk of harm to self or others.	CNO	Completed 9/21/18
		The Director of Education and Director of Social Services will re-educate all RNs and Social Service Staff on new Master Treatment Plan and proper treatment planning, including adding additional problems to the treatment plan when necessary and on the new forms. All full-time nursing and social service staff will be re-trained by 10/5. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Director of Education Director of Social Services	10/10/18
		<u>Sustainability:</u> Random audits will be conducted monthly on 50 charts with a target of 95% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and	CNO Director of Social Services	10/10/18 and Ongoing

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		Medical Executive Committee and Quarterly to the Governing Board.		
A145 PATIENT RIGHTS: FREE FROM ABUSE / HARASSMENT CFR(s) 482.13(c)(3) Section A	Failed to provide needed clothes to promote patient dignity and avoid mental anguish.	A *"Caring Closet"* program was developed for the purpose of providing clothing, footwear, and other essential personal items for patients who may not have the resources to ensure dignity is preserved.	Director of Social Services	10/1/2018
		<u>Sustainability:</u> Daily Leadership Rounds will be conducted to ensure patients have adequate clothing. Findings of Leadership Rounds will be reported daily to nursing administration and weekly to CEO during management meeting	CEO	10/10/18 and Ongoing
A145 PATIENT RIGHTS: FREE FROM ABUSE / HARASSMENT CFR(s) 482.13(c)(3) Section B	Failed to provide patients a place to sit or lie down while being secluded.	Eight new chairs will be purchased to be placed in the seclusion rooms. These chairs will be securely mounted to the floor in a manner that ensures patient safety. New chairs will be ordered by 10/5/2018 and delivery is expected on 11/16/2018. Until new seclusion room chairs arrive, beds will be mounted in seclusion rooms.	CEO	10/5/18
A405 ADMINISTRATION OF DRUGS CFR(s) 482.23(c)	Failed to ensure that nursing staff carried out and documented medication administration per policy and as ordered by the physician.	The Director of Education will conduct in-service training for all Registered Nurses and Licensed Vocational Nurses to re-educate on proper medication administration processes and documentation in compliance with Policy #PHR-159, titled "Medication Administration	Director of Education	10/10/18

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(1), (c)(1)I & (c)(2)		and Records." All full-time nurses will be re-trained by 10/5. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.		
		<u>Sustainability:</u> Random audits will be conducted monthly on 50 charts. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board	CNO	10/10/18 and Ongoing
A630 DIETS CFR(s) 482.28(B)(2)	Failed to ensure that patients had orders for therapeutic diets when needed.	The Chief Nursing Officer, in conjunction with the Dietician and Medical Director will revise the policy 1300.07 for obtaining nutritional consults titled "Nutritional Screen and Assessment" and will re-educate nursing, medical staff and dietician on completion of nutritional screening, orders for special diets and procedure for notification of food service staff. All full-time nurses and food service staff will be re-trained by 10/5. PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	CNO	10/10/18
		<u>Sustainability:</u> Random audits will be conducted monthly on 50 charts, for 90-days after 95% compliance is achieved. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board.	CNO	10/10/18 and Ongoing
A655	Failed to develop a	Utilization Review Plan will be revised to	CFO	9/28/18

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SCOPE OF FREQUENCY OF REVIEW CFR(s) 482.30(c)	Utilization Review Plan that defined cases they reasonable assumed to be Extended Stay Outliers and/or High Cost Outliers and include a process for reviewing those cases.	include all the required elements including a method to identify cases with extended stay outliers and/or high cost outliers and medical necessity of all admissions. A formalized process for reviewing the cases identified will be implemented.	UR Director	
		Sustainability: Standing agenda items identifying extended stay and high cost outliers will be included in the quarterly UR Committee meetings. Additionally, the Utilization Review Plan will be reviewed annually to ensure continued compliance.	CFO UR Director	10/10/18 and Ongoing
A747 INFECTION CONTROL CFR(s) 482.42	Failed to ensure the environment was sanitary to prevent infectious sources or the spread of infection.	Addition of a Housekeeping Supervisor.	Director of Plant Operations	Completed 9/10/18
		Additional staff will be added to the Housekeeping Department.	Director of Plant Operations	10/10/18
		A housekeeping cleaning schedule was developed to address hospital cleanliness including all patient care areas and staff work spaces.	Director of Plant Operations	10/1/18
		An EOC rounding tool was created for use by Director of Plant Operations (DPO)	Director of Plant Operations	10/1/18
		Cleanliness assessment will be added to Mental Health Technicians (MHT) hand-off unit rounds to be conducted at change of shift. All full-time MHTs will be trained on revised hand-off rounds by 10/10 PRN staff not able to attend training will be trained prior to assuming the next scheduled shift. Documentation of training will be evident in staff's education files.	Director of Education	10/10/18

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		Sustainability: Daily rounds conducted by the Housekeeping Supervisor will be submitted to DPO daily and addressed upon finding. Weekly rounds will be conducted by the DPO and reported to the CEO weekly. EOC Leadership rounds will be conducted and reported weekly in management meeting. Results of all rounds will be reported monthly at the Environment of Care Committee and Performance Improvement Committee.	CEO Director of Plant Operations	10/1/18
		The following physical plant issue related to infection control were addressed as follows:	Director of Plant Operations	10/10/18
		- The pump in the water feature is scheduled to be replaced.	Director of Plant Operations	10/3/2018
		- Risers were constructed to lift refrigerators off of the floor.	Director of Plant Operations	8/30/2018
		- Gaps in beds will be sealed.	Director of Plant Operations	10/5/2018
		- Transitions strips were installed at the entrance to all seclusion rooms.	Director of Plant Operations	9/27/2018
		- Cracked shower floors are scheduled to be repaired.	Director of Plant Operations	10/10/2018
		- Peeling laminate and baseboards at Nurses Stations are scheduled to be repaired	Director of Plant Operations	10/10/2018
		Sustainability: DPO will conduct EOC rounds to ensure sustained compliance. Findings of	Director of Plant	10/10/18

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		rounds will be reported monthly at EOC Committee, Performance Improvement Committee and Medical Executive Committee.	Operations	
		Infection Control Rounds conducted weekly by the Director of Infection Control have been expanded and include surveillance of the following areas: - Patient living areas, to include furniture and general living environment - Food in patient refrigerators - Medication room, to include expired supplies, biohazard containment, - Intake department, patient living areas, medication rooms, unit refrigerators, treatment rooms, seclusion rooms, furniture, courtyards, dining room and kitchen.	Director of Infection Control	10/5/18
		<u>Sustainability</u>: Weekly rounds will be conducted by the Director of Infection Control. Any deficient findings will be corrected immediately. The Director of Infection Control will report findings to the Infection Control Committee, EOC Committee and Medical Executive Committee monthly, and Governing Board quarterly.	Director of Infection Control	10/10/18 and Ongoing
		- A deep cleaning of kitchen, including, oven, floors, drains, etc. was complete by an outside vendor.	Chief Financial Officer	8/30/2018
		- Painted “red line” was completed in kitchen to delineate clean from dirty areas. No dirty items such as shipping cartons, etc. will be allowed past the red	Dietary Manager	10/1/2018

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		line.		
		- Cleaning of floor drains has been added to the Dietary Surveillance Rounds Report.	Dietary Manager	10/1/2018
		<u>Sustainability:</u> Weekly rounds will be conducted by the Director of Infection Control. Any deficient findings will be corrected immediately. The Director of Infection Control will report findings to the Infection Control Committee, EOC Committee and Medical Executive Committee monthly, and Governing Board quarterly.	Director of Infection Control	10/10/18 and Ongoing
A810 TIMELY DISCHARGE PLANNING EVALUATIONS CFR(s) 482.43(b)(5)	Failed to initiate and develop a timely discharge plan.	Social Services staff has re-educated social services staff regarding discharge planning requirements as per hospital policy and CMS guidelines, to include effective linkage of patients to post hospital clinical, medical, and behavioral community resources. A discharge planning checklist was created to ensure compliance with policy	Director of Social Services	Completed on 9/28/2018
		<u>Sustainability:</u> Random audits of Discharge Plans will be conducted monthly on 50 charts with a target of 95% compliance for 90-days. Audit results will be reported monthly to Performance Improvement Committee and Medical Executive Committee and Quarterly to the Governing Board	Director of Social Services	10/10/18 and Ongoing